I. PURPOSE

This policy establishes guidelines and procedures for Charlotte-Mecklenburg Police Department (CMPD) employees when in contact with a person experiencing a mental health crisis who may be at risk of death and require proper medical care.

II. POLICY

CMPD recognizes and respects the integrity and paramount value of human life. Consistent with this value, CMPD is committed to protecting the safety of all persons, including those who are experiencing a mental health crisis.

This policy will provide employees with information to assist in identifying persons experiencing a mental health crisis who may be at risk of death during restraint encounters, identifying persons who have a mental illness that requires assistance and/or access to community mental health resources, managing situations in a manner that minimizes the risk to all persons involved, and facilitating medical care for persons as soon as practical.

III. DEFINITIONS

A. At-Risk Person: Any person physically or mentally challenged who poses a risk to themselves or others (e.g., mental disorders, suicidal, patients with Alzheimer's, diabetics, or special needs according to the American Disabilities Act (ADA) regulations).

B. De-escalation: The application of verbal and nonverbal techniques or strategies to reduce the intensity of interactions and the potential for physical altercations.

C. Excited Delirium Syndrome: A serious and potentially deadly medical condition involving psychotic behavior, elevated temperature, and an extreme fight-or-flight response by the nervous system.

D. Mental Health Crisis: An incident in which a person experiences or displays intense feelings or personal distress (e.g., anxiety, depression, anger, fear, panic, hopelessness, etc.) they are unable to manage with their ordinary coping strategies and may cause disruptions in thinking (e.g., visual or auditory hallucinations, delusions, cognitive impairment, etc.). A mental health crisis can result from mental illness, an intellectual or developmental disability, a personal crisis, or the effects of drugs or alcohol.

E. Mental Illness: Any condition characterized by impairment of a person's normal cognitive, emotional, or behavioral functioning and caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma.

IV. PROCEDURES

A. Mental Illness

When responding to a call for service or conducting an interview/interrogation, employees may encounter situations where they interact with a person suspected of suffering from a mental illness.

1. Employees are not required to make a diagnosis of whether a person is mentally ill or what form of mental illness a person may have but will use reasonable judgment and utilize their training to assist in recognizing and evaluating a person who may be suffering from a mental illness.

    a. Verbal Cues

        (1). Illogical thoughts (sharing a combination of unrelated or abstract topics, expressing thoughts of greatness, indicating ideas of being harassed or threatened, exhibiting a preoccupation with death, germs, guilts, or other similar ideas).

        (2). Unusual speech patterns (nonsensical speech or chatter, word repetition, pressured speech, extremely slow speaking).

        (3). Verbal hostility or excitement (talking excitedly or loudly, being argumentative, belligerent, or unreasonably hostile, threatening harm to self or others).

    b. Behavioral Cues

        (1). Physical appearance (inappropriate clothing to the environment).

        (2). Body movements (strange postures or mannerisms, lethargic and sluggish, pacing, repetitive/ritualistic movements).

        (3). Seeing, smelling, or hearing things that cannot be confirmed.

        (4). Confusion about or unawareness of surroundings.

        (5). Lack of emotional response.

        (6). Causing injury to self.

        (7). Nonverbal expression of sadness or grief.

        (8). Inappropriate emotional reactions (overreacting to situations in an overly angry or frightening way, reacting with the opposite of expected emotion).

    c. Environmental Cues

        (1). Strange decorations (aluminum foil, pentagrams, etc.).

        (2). Hoarding of items (garbage, newspapers, etc.).

        (3). Presence of feces or urine on floors or walls.

2. The following guidelines should be utilized when interacting with a person who may be suffering from a mental illness.

   a. Collect as much information on the person as possible from all sources before intervening.

   b. Take your time and eliminate noise and distractions, recognizing that the person may be overwhelmed by external and internal stimuli.

   c. Remain calm and avoid overreacting.

   d. Talk simply and slowly.

   e. Be helpful, patient, and accepting but firm and professional.

   f. Understand that a rational discussion may not take place.

   g. Indicate a willingness to understand.

   h. Recognize that a person's delusions or hallucinations are very real for them.

B. Excited Delirium

1. Excited delirium is a potentially life-threatening condition most commonly seen in males with a history of serious mental illness and/or acute or chronic drug abuse, particularly stimulant drugs such as cocaine, crack cocaine, methamphetamines, amphetamines, or similar agents. Alcohol or substance withdrawal or head trauma may also contribute to excited delirium.

2. MEDIC and/or CFD will be requested immediately if excited delirium is suspected.

3. Persons experiencing excited delirium may be a risk to themselves, the officer, and bystanders. The person may exhibit a combination of delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent or bizarre behaviors, insensitivity to pain, hyperthermia, and increased strength.

4. It is important for officers to recognize when a person may be experiencing excited delirium because the person could potentially die without proper medical attention. The following signs may be exhibited:

   a. A person's ability to focus, sustain, or shift attention is impaired, and they are easily distracted.

   b. A person may be incoherent or ramble, and it may be difficult or impossible to engage with the person in conversation.

   c. A person may exhibit signs of paranoia, fear, and excitability. The presence of police officers may further heighten this feeling.

   d. A person may be disoriented regarding time and/or locations, suffer from misleading perceptions, and/or experience hallucinations or delusions.

e. A person may remove one or more clothing items due to elevated body temperature.

f. A person may possess unusual strength and endurance and appear impervious to pain.

g. A person's symptoms can progress into agitation, anger, and aggressiveness.

h. A person may have a tendency towards violence against people, as well as inanimate objects, particularly glass.

5. Once it is determined that a person may be experiencing excited delirium, the incident will be managed as a medical emergency, in addition to whatever law enforcement response may be required under the circumstances, including the use of reasonable force.

C. Positional and Restraint Asphyxia

1. Positional asphyxia occurs when the person's body position interferes with their ability to breathe. The inability to breathe adequately creates a lack of oxygen, which may result in unconsciousness or suffocation (asphyxiation). The inability to breathe correctly may result from the body's position interfering with the muscular or mechanical function of breathing, from the compromising or blocking of the airway, or from some combination of the following:

a. Hog-tied (handcuffed behind the back, feet bound and raised toward hands, and placed face down) is a body position that can contribute to positional asphyxia. Positional asphyxia may occur when the person is restrained in another position (e.g., handcuffing a person behind the back, which is the preferred method for safety reasons) and is placed face down.

b. Additional factors that may increase the risk of positional asphyxia include:

(1). Obesity

(2). Alcohol and substance use

(3). Enlarged heart

(4). Physical injury

2. Restraint Asphyxia is typically caused by a combination of exhaustion, exertion, fear, and restricted breathing due to restraint or the response to resistance.

D. Role of a Law Enforcement Officer

1. When an officer responds to an incident involving a person in a mental health crisis, the officer will, as soon as practical, request MEDIC and/or CFD (if not initially dispatched), designate a safe location for MEDIC and/or CFD to stage until the scene is secured, and notify their supervisor.

2. Division supervisors will respond to the scene in instances of a person suspected of experiencing excited delirium, positional asphyxia, or restraint asphyxia.

3. Officers responding to a mental health crisis should request an on-duty Crisis Intervention Team (CIT) officer and/or the Community Policing Crisis Response Team (CPCRT) to respond to the scene. If necessary, the Mecklenburg County Mobile Crisis Team (MCT) can also be requested to respond. CIT officers, CPCRT, and MCT will serve as the gateway to community mental health resources. CPRCT and/or MCT will:

   a. Assist in stabilizing the situation.

   b. Complete a mental health assessment, if necessary.

   c. Make referrals/linkages to the Alliance Health partnerships or other vital services as needed.

   d. Conduct follow-up assessments.

4. If CPCRT and/or MCT are unavailable, officers will assess the situation and take appropriate action as needed.

5. If a person appears unarmed, does not pose an immediate threat to escape, or does not pose an immediate threat to the physical safety of themselves, officers, or other persons, the initial arriving officer will wait until backup arrives before attempting to approach the person. Officers will, if practicable, contain the person while maintaining a safe distance. The objective in this situation is to gain the person's voluntary cooperation. One (1) or more of the following may assist in achieving the person's cooperation:

   a. Attempt to de-escalate the situation. Ideally, only one (1) officer should converse with the person. The officer should turn down their radio, project calmness and confidence, and speak in a conversational and non-confrontational manner. Whenever possible, the officer should determine if the person can answer simple questions, which can give the officer an idea of the level of coherence of the person.

   b. Remember, a person's mind may be racing or delusional; officers should be patient and may need to repeat statements and questions several times.

   c. If beneficial and safe to do so, an officer may enlist the assistance of a family member or another person who has a rapport with the person or a mental health professional who can safely participate in attempting to gain the person's cooperation.

6. If the person is armed, combative, or otherwise poses an immediate threat to the physical safety of themselves, officers, or other persons, officers shall employ the amount of force that is reasonable and necessary to protect themselves and others at the scene and to take the person into custody. To practical extents, efforts

should be made to minimize the intensity and duration of the person's resistance and to avoid engaging in a potentially prolonged struggle.

7. Officers will adhere to Directive 600-019 Response to Resistance and local medical protocols when attempting to stop a person from resisting arrest or harming themselves or others (e.g., use of physical restraints, OC, Taser, etc.).

   Officers should use the following control techniques:

   a. Once physical restraints have been applied, if the person is behaving in a manner that could potentially cause self-harm or harm to officers, the person may be held in the prone position as it affords the officers on the scene the safest and most efficient means of controlling the person.

   b. As soon as it is safe for the person and officers on the scene, the person should be rolled onto their side to reduce the likelihood of positional asphyxia or airway compromise. Officers should position themselves in a kneeling position beside the person to provide positional support.

   c. Officers will closely and continuously monitor the person for signs of medical distress such as labored or irregular breathing, unresponsiveness, incoherence, or verbal indications. Officers will notify MEDIC and/or CFD of any observed changes in a person's condition via the Communications Division. Officers should continue to attempt to communicate, calm the person, and obtain medically relevant information (e.g., drugs ingested, known medical conditions, etc.).

   d. If the person becomes unresponsive and stops breathing, handcuffs should be removed, and the person should be placed on their back to begin Cardiopulmonary Resuscitation (CPR).

8. Officers will notify MEDIC and/or CFD via the Communications Division of any force applied to a person. Once MEDIC and/or CFD arrive on the scene, officers will provide a detailed description of the force used, the level/intensity of resistance by the person, and any relevant medical information.

9. If an officer has reason to believe the person ingested contraband, the officer will:

   a. Immediately contact MEDIC and/or CFD and have the person evaluated by emergency medical personnel.

   b. Notify their immediate supervisor.

   c. If the person is not under arrest, ensure that the arrest process continues and the person remains under arrest. The division commander or Operations Command will determine if there is a need to maintain a rotation to guard the person.

   d. Advise Mecklenburg County Intake personnel anytime a person has been treated for ingesting contraband.

10. If an arrest is appropriate, the arrest process will be completed upon the person's release from the medical facility.

11. If MEDIC transports the person to a medical facility, officers will maintain custody of the person.

E. Role of the Communications Division

1. Telecommunicators may recognize a potential case of excited delirium; in this case, they will communicate their observations to the responding officers, contact MEDIC and/or CFD, and request that a CIT officer respond to the incident if available.

2. Telecommunicators are responsible for informing responding officers that MEDIC and/or CFD is responding and their ability to stage.

3. Telecommunicators will immediately relay information provided by officers about a person in a mental health crisis to MEDIC and/or CFD to include, but not limited to, scene security, the person's condition, changes to the person's condition, if officers believe the person ingested contraband, and force applied to the person by officers.

F. Role of MEDIC and/or CFD

1. In accordance with MEDIC dispatch protocols, MEDIC and/or CFD will respond to the staging area of a mental health crisis and await notification that the scene is secure.

2. MEDIC and/or CFD should evaluate and administer appropriate medical care to the person.

3. If a person is determined to be at risk for positional asphyxia, restraint asphyxia, or excited delirium, MEDIC should transport the person to an emergency medical facility.

4. For a mental health crisis where a person is not at risk for positional asphyxia, restraint asphyxia, or excited delirium, MEDIC and/or CFD should evaluate the person to determine if there is a need for MEDIC to transport to an emergency medical facility. If emergency medical personnel determine a person does not need to be transported by MEDIC and advise an officer can transport the person, the transporting officer will properly document the emergency medical personnel's decision and monitor the person's breathing closely. When possible, the transporting officer should have a second officer accompany them to monitor the person. If a second officer is unavailable, the transporting officer should stop the vehicle periodically and confirm that the person is conscious, alert, and can breathe normally.

G. Community Mental Health Resources

1. The following guidelines should be utilized when seeking assistance or accessing community mental health resources.

   a. Evaluate prior contact with police to include:

      (1). Type of problem

      (2). Prior violence

      (3). Method of resolution

   b. Gather information regarding the situation from family members, neighbors, and/or complainant(s).

2. Community mental health resources include, but are not limited to:

   a. Alliance Health

      Alliance Health is the Managed Care Organization (MCO) for Mecklenburg County, which is the service delivery organization for mental health, substance use disorder, and developmental disability services.

   b. Community Assistance: Response, Engage, Support Team (CARES)

      CARES is a civilian-only response team consisting of two (2) masters-level clinicians who respond to or assist in responding to low-level, non-violent calls for service related to homelessness and mental health. CARES is currently only available in Central and Metro Division, Monday-Friday from 0700-1500 hours.

   c. Community Policing Crisis Response Team (CPCRT)

      CPCRT consists of crisis intervention team (CIT) trained officers paired with masters-level mental health clinicians who respond to or assist in responding to incidents involving a mental health crisis. See the Community Policing Crisis Response Team SOP.

   d. Crisis Intervention Team (CIT)

      CIT consists of officers who have received specialized training to de-escalate mental health crisis situations involving at-risk persons and divert persons into treatment services in partnership with community providers. See the Crisis Intervention Team (CIT) SOP.

   e. Mecklenburg County Mobile Crisis Team (MCT):

      MCT consists of masters-level clinicians, clinical social workers, and professional counselors contracted with The Sante' Group, who have extensive training in de-escalation and mental health crisis intervention and

can assist CMPD employees in interacting with a person experiencing a mental health crisis. MCT is available 24/7/365.

H. Mental Health Training

1. Entry-Level Training

CMPD employees who may be expected to come into contact with or communicate with a person in a mental health crisis are required to obtain documented entry-level behavioral health training.

2. In-Service Training

a. CMPD employees who may be expected to come into contact with or communicate with a person in a mental health crisis are required to obtain documented refresher training annually. Additional training may be conducted at the discretion of the Training Academy director.

b. Officers are encouraged to volunteer to attend the forty (40) hour Crisis Intervention Team training.

V. REFERENCES

500-002 Confinement of Arrestees and Booking Procedures
500-008 Prisoner Transport
600-019 Response to Resistance
900-008 Cardiopulmonary Resuscitation (CPR)
Crisis Intervention Team SOP
Community Policing Crisis Response Team SOP
BLET Lesson Plans
MEDIC Dispatch Protocols
FBI Responding to Persons with Mental Illness Indicators
CALEA

The previous version of Directive 500-003 was titled Management of Subjects with Mental Illness/Extreme Distress and was published on 02/06/2020.